Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ORTHOPEDIC PHYSICAL THERAPY
9150 HUEBNER RD STE 115
SAN ANTONIO TX 78240

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
#54

MFDR Tracking Number
M4-11-3160-02

MFDR Date Received
MAY 17, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "VERBAL AUTHORIZATION PROVIDED BY ADJUSTER."

Amount in Dispute: $1,836.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim 99L0000609601 is in the Texas Star Network…Texas Mutual's utilization review agent, Coventry Workers' Comp Services, on 9/17/10 received a preauthorization request for physical therapy from the requestor. On 9/20/10 Coventry contacted Dorean with Orthopedic Physical Therapy, the requestor, to inform them that because the referral for the physical therapy came from an out of network doctor, Coventry could not process the preauthorization request…There is no evidence the requestor received preauthorization from Texas Mutual or its utilization review agency for the disputed dates 9/14/10 through 10/11/10. Absent such, no payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2010 Through October 11, 2010	CPT code 97110 CPT code 97140-59 CPT code 97110 CPT code 97001 CPT code 97002	$1,836.72	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 18, 2010

- CAC-B22 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS
- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.
- 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
- 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

Explanation of benefits dated May 11, 2011

- CAC-B22 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.
- 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
- 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

Issues

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §§133.305 and 133.307?

Findings

1. §133.305 (a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a) (5) of the same rule as "Health care **not** [emphasis added] delivered, or arranged by a certified workers" compensation health care network as defined in Insurance Code Chapter 1305 and related rules…" 28 Tex. Admin. Code §133.307 (a) (1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care…" Out-of-network health care is addressed at Insurance Code Chapter 1305, section 1305.006 titled *Insurance Carrier Liability for Out-of-Network Health Care*. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. This dispute may not be resolved pursuant to 28 Tex. Admin. Code §133.307; for that reason, no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 25, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.